Medicine and Money

The high price of aging

A 78-year-old Vermont woman with breast cancer, hypercholesterolemia, and arthritis must pay nearly $300 a month for prescription drugs at her local pharmacy. But if she takes a bus trip into Canada, the same prescriptions will cost only half as much.

Public Citizen, a nonprofit Washington watchdog group, invited US presidential candidates to join a "Drug Price Refugee" bus trip to Canada last January. The trip was arranged for New Hampshire seniors, who were paying over double the price charged to such favored customers as HMOs and the Departments of Defense and Veterans Affairs. Medicines are cheaper in Canada because the Canadian government negotiates substantially lower drug prices with pharmaceutical manufacturers.

Congressman Bernard Sanders, Independent from neighboring Vermont, recalled, "You can't walk down a main street in Vermont without someone coming up and saying, 'Bernie, you've got to do something about the high cost of prescription drugs.' "

On the West Coast, Republican Senator Slade Gorton of Washington State said his constituents often go across the Canadian border to buy cheaper drugs: "I was astounded to learn that for the top 10 most commonly prescribed drugs, average prices are 64% lower in Canada than in Washington State. That is outrageous."

President Clinton is trying to extend the Medicare program so that it partially covers the high cost of prescription drugs. On April 10, Clinton released a new study by the Department of Health and Human Services showing that Medicare beneficiaries without drug coverage lack insurance against high costs. They also have no access to the discounts and rebates that insured persons receive. Medicare recipients without drug coverage are also five times more likely to report being unable to purchase prescription drugs as those with coverage. In addition to the millions of completely uninsured, nearly half of seniors with Medigap did not have their coverage for the entire year. Because of the limited information about price discounts, the Department of Health and Human Services will hold a conference this summer that will focus on prescription drug pricing practices.

Prescription drug spending and utilization are growing rapidly, more than twice the growth in funds spent in other areas of health care. Nationwide spending on medicines increased at an annual rate of 12% from 1993 to 1998, compared with 5% for all other types of health spending. Prescription drugs now account for one sixth of all out-of-pocket health spending by the elderly (http://aspe.hhs.gov/health/reports/drugstudy).

Currently, one third of Medicare beneficiaries have no drug coverage at all. Older Americans constitute 13% of the population, but this segment of our society accounts for more than one third of the nation's drug expenditure.

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One in eight seniors cannot afford the cost of prescription drugs

AP/Stephan Savoia

99-year-old Ruth McPherson, pictured listening to Senator John McCain, is the oldest resident of Atkinson, New Hampshire. Will politicians cut her prescription costs?

The National Committee to Preserve Social Security and Medicare, with over 5 million members, found that one in eight seniors cannot afford the cost of prescription drugs. These include the wide array of new cardiac drugs, diuretics, psychoactive drugs, and gastrointestinal preparations, which are not covered by Medicare. Seniors must pay for these prescriptions directly.

In Washington, the issue has finally been acknowledged. Currently, 29 bills relating to Medicare and prescription drug coverage are before the House and Senate. Clinton's plan, which has yet to become law, would give Medicare beneficiaries the option to pay for a prescription drug benefit that would cover half of all drug costs up to $5,000 when fully phased in, including a stop-loss provision to protect seniors against catastrophic drug costs. The hope is that the premiums would be affordable, perhaps $44 per month, to both beneficiaries and the program, and seniors would be able to gain access to needed medications. The president's plan also includes reforms to make Medicare more competitive and efficient. He promotes dedicating $432 billion to Medicare to help pay for the prescription drug benefit and to improve the program's financing, with the goal of extending the life of its trust fund to the year 2030.

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The pharmaceutical industry opposes Mr Clinton's plan. Its spokesperson, Alan Holmer, said: "Loss of profits through price controls would inevitably lead to an adverse impact on pharmacological research . . . and create a disincentive for the industry to invest in the diseases of aging."

Public Citizen says that the industry spent $30 million last year to plaster the fictitious senior "Flo" on television and in full-page newspaper advertisements. The accompanying message said: "Keep big government out of your medicine cabinet."

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A book to make you think

Blind Eye: How the Medical Establishment Let a Doctor Get Away with Murder James B Stewart, Simon and Schuster, $17.50, pp 334

There is ample precedent for physicians flouting the Hippocratic admonition, "First, do no harm," and, directly or indirectly, accounting for multiple deaths. Dr Joseph Mengele's handiwork has been much documented; more vicariously, Dr Joseph Guillotin's invention did away with a fair number of folk, as did Dr Richard Gatling's gun, which fired 350 shots a minute.

But Dr Michael Swango, the subject of this meticulously researched and highly readable book, was a fully fledged psychopath who killed for the sheer thrill of it. And even though as many as 60 fatal poisonings could be attributed to him, his charm and glib persuasiveness allowed him to move on with impunity from one medical institution to another. As a medical student at Southern Illinois University, he became known as "Double-0 Swango, licensed to kill" after 5 patients under his care died mysteriously.

At each hospital, the huge cloud of suspicion that enveloped Swango was wafted away by physicians and administrators fearful of litigation and sullied reputations. Even today, he's serving a jail term not for murder but for possession of narcotics and fraud and could be at large again soon.

That a blind eye could have been turned to Swango's persona and record is remarkable and somewhat chilling. He was fascinated by Nazism, the Holocaust, and serial and mass killers such as Jim Jones, the charismatic leader of the People's Temple, whose thousand-odd followers he persuaded to commit mass suicide in 1978. Swango kept a scrapbook of pictures of gory car crashes and collected an arsenal of weapons and an assortment of poisons in his apartments.

The cover up was worst at Ohio State University, the prestigious medical school where Swango was admitted to an internship. Despite a number of suspicious deaths reported by nurses who had seen Swango enter the patients' rooms with a syringe, the administration dismissed the concerns as gossip and overreaction. Fearful of the public relations damage and possible loss of funding, they closed ranks and later refused any cooperation with Pulitzer Prize winning author Stewart. In 1986, Swango's license to practice medicine was suspended when he went to prison for attempting to poison his coworkers, yet when he was released in 1987, he was able to enter a residency in internal medicine in South Dakota. Even though his past caught up with him there, he went on to secure a psychiatric residency in New York state, before fleeing to Zimbabwe, where he was again suspected of poisoning patients and again dismissed. Incredibly, he moved on to practice in Zambia, where he was suspected and fired once again.

Stewart's is a cautionary tale calling for urgent and stringent legislation and improved reporting mechanisms so that checks on rogue physicians won't continue to be thwarted by fear of litigation and bad press, and by a closing of ranks and a suspension of belief by fellow doctors.

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